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# UNITED NATIONS POPULATION FUND

## REPORT OF THE EXECUTIVE DIRECTOR FOR 1993

Page

PROGRAMME AND FINANCIAL HIGHLIGHTS ..... 2

I. TOWARDS INTEGRATED REPRODUCTIVE HEALTH CARE ..... 7

A. The family planning revolution ..... 7

B. Satisfying unmet need ..... 8

C. Empowering women ..... 8

II. UNFPA PROGRAMME IN 1993 ..... 9

A. Family planning and reproductive health care ..... 9

1. Improving the quality of services ..... 10
2. Integrating family planning into reproductive health care ..... 12
3. Strengthening IEC in support of family planning services ..... 13
4. Linking women's economic activities and reproductive behaviour ..... 14

B. Strategic programming and technical assistance ..... 15

1. Programme review and strategy development ..... 16
2. UNFPA Country Support Teams ..... 16

III. STATUS REPORT ON UNFPA IMPLEMENTATION OF GENERAL ASSEMBLY RESOLUTION 47/199 ..... 18

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/...

UNFPA IN 1993:

PROGRAMME AND FINANCIAL HIGHLIGHTS

Pledges and contributions

- Income in 1993 (provisional) totalled $219.6 million, compared to 1992 income of $238.2 million, a decrease of 7.8 per cent.

- Pledges to UNFPA's general resources in 1993 totalled $216.6 million, $17.2 million less than in 1992, a percentage decrease of 7.4 per cent. At year's end, cumulative pledges through 1993 totalled $2.9 billion from a cumulative total of 164 donors.

- The number of donors in 1993 totalled 101. There were three first-time donors in 1993 (Costa Rica, Ireland and Namibia).

- The Fund's ongoing efforts to seek additional resources for population projects and programmes generated $14.8 million for multi-bilateral projects and $10.9 million for programmes through other financial arrangements in 1993.

Allocations and expenditures

- Total (provisional) programmable resources for 1993 were $205.6 million, compared to $184.6 million for 1992.

- Project allocations in 1993 totalled $206.1 million, including $35.4 million of unspent allocations from 1992. Project allocations in 1992 totalled $163.6 million, including $40.2 million of unspent allocations from 1991. Project expenditures (provisional) for 1993 totalled $146.3 million compared to project expenditures in 1992 of $128.2 million. The resource utilization rate (expenditures divided by programmable resources, as approved by the Governing Council in decision 89/46 B) was provisionally 82.8 per cent in 1993 compared to 81.8 per cent in 1992.

- Expenditures (provisional) in 1993 totalled $215.4 million, compared to $193.6 million in 1992. The 1993 figure includes $116.5 million for country programmes, compared to $103.1 million in 1992; $29.8 million for intercountry (regional and interregional) programmes, compared to $25.1 million for 1992. Total administrative and programme support services (APSS) expenditures for both headquarters and field offices were $45.1 million in 1993 (net of $2.9 million overhead credits), compared to $42.6 million in 1992 (net of $2.5 million overhead credits). Field office costs were $20.5 million in 1993 compared to $18.8 million in 1992. Technical support services (TSS) under the successor support-cost arrangements approved by the Governing Council in decision 91/37 were $17.4 million. Administrative and operational services (AOS) costs, set by the Governing Council at 7.5 per cent of expenditures of country activities, were $6.6 million.

- 480 new projects were approved in 1993, amounting to $72.0 million, compared to 429 new projects in 1992 amounting to $43.5 million.

- At year's end, UNFPA was assisting 1,560 projects: 1,262 country, 127 regional and 171 interregional projects. The breakdown of country projects by region was as follows: 493 country and regional projects in Africa; 384 in Asia and the Pacific; 208 in Latin America and the Caribbean; 177 in the Arab States and Europe.

. For allocations in 1993 by major function, by geographical area, and by country category, see data on page 5.

Country activities

. 368 new country projects were approved in 1993, amounting to $60.4 million or 36.8 per cent of total allocations of $164.1 million to country projects, compared to 289 new country projects in 1992 amounting to $24.9 million or 24.2 per cent of total expenditures for country projects in 1992.

. Allocations to continuing country projects amounted to $103.7 million or 63.2 per cent of total allocations to country projects, compared to expenditures for continuing country projects amounting to $77.9 million in 1992 or 75.8 per cent of total expenditures for country projects.

. For allocations to country activities, by work plan category, and by priority and non-priority country and regional activities, see table, page 6.

Priority countries

. In accordance with the criteria and thresholds approved by the Governing Council in decision 88/34 A, adopted at its thirty-fifth session in June 1988, effective 1 January 1992, 58 countries have been given priority status. By geographic area, these priority countries number: Africa, 32; Asia and the Pacific, 17; Latin America and the Caribbean, 5; and Arab States, 4. (For a list of priority countries see p. 6.)

. Of the total amount of resources allocated to country programmes and projects in 1993, 72.6 per cent was allocated to these priority countries, compared to 75.8 per cent of expenditures in 1992.

. Total allocations in 1993 to priority countries amounted to $119.0 million, compared to $77.9 million in expenditures for priority countries in 1992.

Intercountry activities

. Allocations for intercountry activities (regional and interregional) totalled $41.9 million in 1993, compared to $25.5 million in expenditures in 1992. By category of activity, these allocations were: regional, $16.6 million in 1993, compared to $9.8 million in expenditures in 1992; interregional, $25.5 million in 1993, compared to $15.5 million in expenditures in 1992.

. Intercountry programmes accounted for 20.4 per cent of 1993 total allocations, compared to 19.8 per cent of expenditures in 1992.

Execution of projects

. The number of projects directly executed by Governments in 1993 numbered 473, compared to 365 in 1992, and totalled $42.4 million or 20.6 per cent of total 1993 programme allocations, compared to $27.4 million or 21.4 per cent of programme expenditures in 1992.

. For allocations in 1993 by executing agency, see table, page 5.

Programme Review and Strategy Development missions

. In 1993, UNFPA undertook Programme Review and Strategy Development (PRSD) missions to five countries - two in Africa (Chad and Zambia) and three in the Asia and the Pacific Region (Islamic

Republic of Iran, Maldives and the Philippines). Total missions (Programme Review and Strategy Development and Basic Needs Assessment missions) conducted since 1977 through 1993 are 189.

Administration and personnel

In 1993, administrative and programme support services (APSS) expenditures (provisional), including both headquarters and field office costs, were $45.1 million (net of $2.9 million of overhead credits) or 20.5 per cent of the 1993 total estimated income of $219.6 million. Comparable administrative expenditures in 1992 were $42.6 million, or 17.9 per cent of the 1992 income of $238.2 million.

As of 1 January 1993, in accordance with Governing Council decisions 85/20 of June 1985, 86/35 of June 1986, 87/31 of June 1987, 88/36 of June 1988, 89/49 of June 1989, 90/36 of June 1990, 91/36 of June 1991, and 93/28 of June 1993, the total number of authorized budget posts was 837, comprising 304 Professional (including 124 national programme officers) and 533 General Service staff. These include 105 Professional and 135 General Service posts at headquarters, 2 Professional and 2 General Service posts in Geneva and 197[1] Professional and 396 local General Service posts in the field.

The percentage of women on UNFPA's Professional staff at headquarters and in the field reached 44 per cent in 1993, one of the highest percentages among United Nations agencies and organizations. In 1994, the percentage is expected to continue to increase.

UNFPA continued to maintain a close operational relationship with UNDP, which also provides the Fund on a reimbursable basis with some administrative support for financial and computer services, for personnel administration and travel services and for the processing of Governing Council/Executive Board documents. Following agreement between UNDP and UNFPA on the subvention arrangement, approved by the Governing Council at its thirty-fifth session (decision 88/36), UNFPA's reimbursement to UNDP for the services rendered was set in the budget at $3.9 million for the biennium 1992-1993. In 1993, UNFPA reimbursed UNDP the amount of $1.5 million.

[1]Includes 124 national programme officers.

## UNFPA PROGRAMME IN 1992 AND 1993: AT A GLANCE

(Data for 1992 are expenditures; data for 1993 are allocations[1])

### UNFPA assistance by major function

| | In thousand $US | | Percentage of total programme | |
|---|---|---|---|---|
| | 1992 | 1993 | 1992 | 1993 |
| Family planning | 66,624 | 104,102 | 52.0 | 50.5 |
| Communication and education | 19,134 | 37,660 | 14.9 | 18.3 |
| Basic data collection | 8,599 | 13,249 | 6.7 | 6.4 |
| Population dynamics | 11,603 | 13,959 | 9.1 | 6.8 |
| Formulation and evaluation of population policies | 11,299 | 17,846 | 8.8 | 8.7 |
| Implementation of policies | 28 | 79 | 0.0 | 0.0 |
| Multisector activities | 5,536 | 8,598 | 4.3 | 4.2 |
| Special programmes | 5,409 | 10,573 | 4.2 | 5.1 |
| Total | 128,232 | 206,066 | 100.0 | 100.0 |

### UNFPA assistance by geographical region

| | In thousand $US | | Percentage of total programme | |
|---|---|---|---|---|
| | 1992 | 1993 | 1992 | 1993 |
| Africa | 37,049 | 59,333 | 28.9 | 28.8 |
| Arab States and Europe | 10,728 | 23,215 | 8.4 | 11.3 |
| Asia and the Pacific | 49,557 | 76,826 | 38.6 | 37.3 |
| Latin America and the Caribbean | 15,396 | 21,295 | 12.0 | 10.3 |
| Interregional and Global | 15,502 | 25,397 | 12.1 | 12.3 |
| Total | 128,232 | 206,066 | 100.0 | 100.0 |

### UNFPA assistance by country/intercountry category

| | In thousand $US | | Percentage of total programme | |
|---|---|---|---|---|
| | 1992 | 1993 | 1992 | 1993 |
| Country | 102,855 | 164,094 | 80.2 | 79.6 |
| Intercountry | 25,377 | 41,972 | 19.8 | 20.4 |
| Total | 128,232 | 206,066 | 100.0 | 100.0 |

### UNFPA assistance by country category, all regions

| | In thousand $US | | Percentage of total country programme | |
|---|---|---|---|---|
| | 1992 | 1993 | 1992 | 1993 |
| Priority country | 77,914 | 119,066 | 75.8 | 72.6 |
| Other country | 24,941 | 45,028 | 24.3 | 27.4 |
| Total | 102,855 | 164,094 | 100.0 | 100.0 |

### UNFPA assistance by executing agency

| | In thousand $US | | Percentage of total programme | |
|---|---|---|---|---|
| | 1992 | 1993 | 1992 | 1993 |
| Government-executed projects | 27,460 | 42,400 | 21.4 | 20.6 |
| United Nations | 14,064 | 14,469 | 11.0 | 7.0 |
| Regional commissions | 5,283 | 3,884 | 4.1 | 1.9 |
| ILO | 6,123 | 8,424 | 4.8 | 4.1 |
| IBRD | 144 | 103 | 0.1 | 0.1 |
| FAO | 1,722 | 5,102 | 1.3 | 2.5 |
| UNESCO | 6,720 | 7,448 | 5.2 | 3.6 |
| UNEP | 0 | 0 | 0.0 | 0.0 |
| WHO | 12,790 | 12,330 | 10.0 | 6.0 |
| UNICEF | 2,204 | 1,724 | 1.7 | 0.8 |
| UNIDO | 31 | 33 | 0.0 | 0.0 |
| UNFPA[2] | 31,135 | 76,347 | 24.3 | 37.1 |
| UNRWA | 51 | 214 | 0.0 | 0.1 |
| Non-governmental organizations | 19,453 | 32,108 | 15.2 | 15.6 |
| UNDP (OPS) | 1,052 | 1,480 | 0.8 | 0.7 |
| Total | 128,232 | 206,066 | 100.0 | 100.0 |

[1] Expenditure data for 1993 are not available until after the due date for submission of this document to the Executive Board.

[2] Includes UNFPA assistance to procurement for Governments' projects as follows: $21.8 million in 1992 and $29.5 million in 1993.

UNFPA expenditures (1992) and allocations (1993), by region

| By major sector | AFRICA (SUB-SAHARAN) (in US$ 000) 1992 | 1993 | Percentage of total programme 1992 | Percentage of total programme 1993 | ARAB STATES AND EUROPE (in US$ 000) 1992 | 1993 | Percentage of total programme 1992 | Percentage of total programme 1993 | ASIA AND THE PACIFIC (in US$ 000) 1992 | 1993 | Percentage of total programme 1992 | Percentage of total programme 1993 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Family planning | 12,837 | 22,946 | 34.7 | 38.7 | 5,152 | 12,739 | 48.0 | 54.9 | 34,992 | 49,138 | 70.6 | 64.0 |
| Communication and education | 7,994 | 14,055 | 21.6 | 23.7 | 1,451 | 2,985 | 13.5 | 12.9 | 5,104 | 10,945 | 10.3 | 14.2 |
| Basic data collection | 3,711 | 5,866 | 10.0 | 9.9 | 1,168 | 2,247 | 10.9 | 9.7 | 1,679 | 2,798 | 3.4 | 3.6 |
| Population dynamics | 4,121 | 4,485 | 11.1 | 7.6 | 1,848 | 2,304 | 17.2 | 9.9 | 2,968 | 3,905 | 6.0 | 5.1 |
| Formulation and evaluation of population policies | 5,065 | 7,870 | 13.7 | 13.3 | 61 | 1,160 | 0.6 | 5.0 | 1,524 | 2,503 | 3.1 | 3.3 |
| Implementation of policies | 2 | 0 | 0.0 | 0.0 | 0 | 0 | 0.0 | 0.0 | 0 | 0 | 0.0 | 0.0 |
| Multisector activities | 1,710 | 2,115 | 4.6 | 3.6 | 585 | 1,008 | 5.5 | 4.3 | 1,309 | 2,090 | 2.6 | 2.7 |
| Special programmes | 1,609 | 1,996 | 4.3 | 3.4 | 463 | 772 | 4.3 | 3.3 | 1,981 | 5,447 | 4.0 | 7.1 |
| TOTAL REGION | 37,049 | 59,333 | 100.0 | 100.0 | 10,728 | 23,215 | 100.0 | 100.0 | 49,557 | 76,826 | 100.0 | 100.0 |
| By country category | | | | | | | | | | | | |
| Priority country | 29,192 | 45,493 | 78.8 | 76.7 | 2,605 | 6,760 | 24.3 | 29.1 | 42,860 | 61,359 | 86.5 | 79.9 |
| Other country | 3,749 | 7,890 | 10.1 | 13.3 | 7,159 | 14,184 | 66.7 | 61.1 | 3,885 | 9,479 | 7.8 | 12.3 |
| TOTAL COUNTRY | 32,941 | 53,383 | | | 9,764 | 20,944 | | | 46,745 | 70,838 | | |
| Regional | 4,108 | 5,950 | 11.1 | 10.0 | 964 | 2,271 | 9.0 | 9.8 | 2,812 | 5,988 | 5.7 | 7.8 |
| TOTAL REGION | 37,049 | 59,333 | 100.0 | 100.0 | 10,728 | 23,215 | 100.0 | 100.0 | 49,557 | 76,826 | 100.0 | 100.0 |

| By major sector | LATIN AMERICA AND THE CARIBBEAN (in US$ 000) 1992 | 1993 | Percentage of total programme 1992 | Percentage of total programme 1993 | INTERREGIONAL AND GLOBAL (in US$ 000) 1992 | 1993 | Percentage of total programme 1992 | Percentage of total programme 1993 |
|---|---|---|---|---|---|---|---|---|
| Family planning | 6,980 | 11,018 | 45.3 | 51.7 | 6,664 | 8,260 | 43.0 | 32.5 |
| Communication and education | 1,968 | 3,766 | 12.8 | 17.7 | 2,617 | 5,909 | 16.9 | 23.3 |
| Basic data collection | 1,798 | 1,770 | 11.7 | 8.3 | 243 | 567 | 1.6 | 2.2 |
| Population dynamics | 1,552 | 1,557 | 10.1 | 7.3 | 1,115 | 1,708 | 7.2 | 6.7 |
| Formulation and evaluation of population policies | 1,647 | 1,287 | 10.7 | 6.0 | 3,001 | 5,028 | 19.4 | 19.8 |
| Implementation of policies | 0 | 0 | 0.0 | 0.0 | 26 | 79 | - | - |
| Multisector activities | 879 | 1,056 | 5.7 | 5.0 | 1,053 | 2,329 | 6.8 | 9.2 |
| Special programmes | 572 | 841 | 3.7 | 4.0 | 783 | 1,517 | 5.1 | 6.0 |
| TOTAL REGION | 15,396 | 21,295 | 100.0 | 100.0 | 15,502 | 25,397 | 100.0 | 99.7[1] |
| By country category | | | | | | | | |
| Priority country | 3,257 | 5,455 | 21.2 | 25.6 | | | | |
| Other country | 10,148 | 13,474 | 65.9 | 63.3 | | | | |
| TOTAL COUNTRY | 13,405 | 18,929 | | | | | | |
| Regional | 1,991 | 2,366 | 12.9 | 11.1 | | | | |
| TOTAL REGION | 15,396 | 21,295 | 100.0 | 100.0 | | | | |

Priority Countries (as modified in 1992 in accordance with 88/34 A)

Africa:
Angola, Benin, Burkina Faso, Burundi, Central African Republic, Chad, Comoros, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Togo, Uganda, United Republic of Tanzania, Zaire, Zambia and Zimbabwe.

Arab States and Europe
Egypt, Somalia, Sudan, Yemen.

Asia and the Pacific
Afghanistan, Bangladesh, Bhutan, Cambodia, China, Korea DPR, India, Indonesia, Lao People's Democratic Republic, Maldives, Myanmar, Nepal, Pakistan, Philippines, Solomon Islands, Sri Lanka, Viet Nam.

Latin America and the Caribbean
Bolivia, Dominican Republic, Haiti, Honduras and Nicaragua.

[1] Figure does not add to 100 due to rounding

# I. TOWARDS INTEGRATED REPRODUCTIVE HEALTH CARE

## A. The family planning revolution

1. The past few decades have witnessed a family planning revolution, most of it taking place in the developing world. In 1960-1965, there were some 31 million contraceptive users. In 1994, there were 446 million, 399 million of whom were using modern methods of contraception.[2] This revolution was fueled in part by the invention of modern contraceptives, which themselves were a product of a technological revolution that helped to develop systematic, long-lasting, effective and reversible methods of contraception.

2. The family planning revolution helped to lower fertility rates dramatically. It broadened contraceptive choice and improved the quality of services. But it did not place women at the centre of the family planning process or give them the power to choose. In fact, it gave rise to concerns that modern contraceptive technology could be used to control women rather than to empower them. It concentrated on reducing the number of children per couple and placed a disproportionate burden of regulating fertility on women. The choice of contraceptives was not necessarily based on the needs or preferences of women but rather reflected the biases of governments, donors and service providers. As a result, the contraceptives provided did not always address women's reproductive health concerns or satisfy individual needs for contraception.

3. The revolution in contraceptive use underscores the strengths and weaknesses of traditional family planning programmes. The experience of the past 25 years shows that strong, well-managed programmes are highly effective. They have helped to achieve smaller families, prevent unwanted births, improve the health of mothers and children, and bring about more balanced rates of population growth. Most importantly, they have saved lives. They have done so in many different countries throughout the world and in a wide variety of social, cultural and economic settings. It is generally accepted, moreover, that permanent declines in fertility can be reached only through widespread voluntary use of modern family planning. Extending family planning services, therefore, has become a priority of international development programmes, both as an end in itself and as a means of promoting other development goals.

4. Family planning programmes satisfied a large existing need, especially among women burdened by frequent child-bearing. They also helped to increase contraceptive prevalence rates in nearly all developing countries -- from less than 10 per cent of couples in the 1960s to an estimated 55 per cent in 1993. This very success, however, reveals one of the main weaknesses of past programmes, namely, the overwhelming concern for quantitative achievements and the corresponding emphasis on demographic targets. Such emphasis at times led to a narrow choice of methods rather than to a wide choice of methods that could accommodate individuals' needs and preferences. Traditional programmes also tended to give inadequate attention to the role and responsibilities of men, neglect the reproductive needs of adolescents, and focus on easier-to-reach sectors of the population rather than on those living in remote rural areas, many of whom were most in need of such services.

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[2] The 1960-1965 figure is from Mahmoud Fathalla, "Contraceptive Research and Development: A Woman-Centred Approach", paper presented to the Round Table on Women's Perspectives on Family Planning, Reproductive Health and Reproductive Rights", Ottawa, Canada, 26-27 August 1993. (The Round Table was part of the preparatory process of the International Conference on Population and Development.) The 1994 estimate is for married women and is from an update of contraceptive requirements for 1994-2005 prepared by UNFPA in collaboration with The Population Council, the findings of which are being submitted to the Executive Board this year in document DP/1994/47.

## B. Satisfying unmet need

5. The notion of unmet need refers to those individuals or couples who want to avoid an unwanted pregnancy but are not practising contraception. It includes those who either want no more children or wish to postpone the birth of their next child. The current unmet need for modern family planning methods is estimated at 120 million women, or approximately 15 per cent of all married women of reproductive age. This figure, however, does not include the substantial and growing numbers of sexually active unmarried individuals who want and need family planning information and services but do not have access to them. Nor does it include those individuals and couples who are practising contraception but are not satisfied with the method they are currently using.

6. A key to satisfying this unmet need is to build upon the solid base of existing family planning programmes and to provide family planning services within the broader framework of sound reproductive health care services. It also requires improving the quality of the care provided. This involves, inter alia, providing a method mix that meets the specific needs of individual users; improving the technical competence of service providers; developing culturally appropriate and understandable information, education and communication (IEC) materials; providing effective counselling to help users select and practise contraception; promoting male participation in family planning programmes and greater responsibility in the process of reproduction; and assisting users in making voluntary and informed choices.

7. The aim is to improve upon the traditional maternal and child health (MCH) approach by adopting a more comprehensive reproductive health care approach that includes family planning. Reproductive health care services seek to ensure that people have the ability to reproduce, to regulate their fertility and to have healthy and responsible sexual relationships. The emphasis on reproductive health reflects a commitment to promote good health and to prevent and treat infectious disease, not only during pregnancy and at childbirth, but also throughout people's lives, from adolescence through adulthood. It also involves a commitment to prevent and treat infertility and sub-fecundity and to prevent and treat sexually transmitted diseases (STDs), including HIV/AIDS.

8. This more comprehensive and integrated approach gives priority to women as women and not exclusively as mothers. It is therefore reproductive health care, as opposed to maternal health care. It also addresses the family planning and reproductive health needs of men, encouraging them to be more responsible partners in sexual relationships and in the process of reproduction. Intensifying men's involvement in reproductive health care not only helps to bring about a more equal sexual and reproductive partnership between men and women, it also tends to increase contraceptive use.

## C. Empowering women

9. In most societies, men are the decision makers. As sexual partners, they tend to assume a dominant role, often deciding, or at least greatly influencing, their partners' choice of contraception. But women have to bear the consequences of this choice. They become pregnant and bear children, suffer the ill-health associated with frequent and untimely reproduction, endure greater hardships from the long-term effects of sexually transmitted diseases, are more susceptible to HIV infection, and face a heavier social, psychological and societal burden for a couple's inability to have children.

10. Women's health and status are inseparable. The key to women's full participation in all aspects of reproductive life is free and informed choice and mutual respect. It is not enough to provide a wide range of contraceptives and to deliver a full range of services. Women must be at the centre of the reproductive health care/family planning process and have the power to choose and to make decisions, both within society and within the family.

11. Social justice and respect for women's dignity are thus at the core of the empowerment of women. So is reproductive self-determination. All three are inspired by a respect for individual rights and for the right to choose.

12. Social justice means ensuring that women have equal access to education, are guaranteed equal opportunity to work and receive equal pay for equal work. It also means eliminating all legal, social, cultural, political and economic barriers against women and assisting women in establishing and realizing their rights, particularly those that relate to sexual and reproductive health. When extended to the economic sphere, it means, among other things, striving to end women's poverty and dependence, improving their ability to earn income, helping them to achieve economic self-reliance and obtain credit, and enabling them to inherit, own and dispose of property.

13. Respect for women's dignity ultimately means publicly recognizing the value of the girl child; treating women as equals, both in the family and in society; and allowing women to realize their full potential. In the context of reproductive self-determination, it means sharing the responsibility for child-bearing and child-rearing with men; involving women in shaping reproductive health policies and in developing strategies to implement these policies; employing more women as health-care providers and researchers in the field of contraception; respecting a woman's choice of contraceptive, including the choice not to use contraception; and adequately addressing reproductive-tract infections and STDs. Perhaps most importantly, it means combatting violence against women and girls, including sexual violence and abuse.

14. During the 1980s, a number of countries made progress in expanding reproductive health care and, correspondingly, in increasing people's opportunities to exercise their reproductive rights and choices. However, there are still many countries where people either do not have full access to such services or are denied the right to choose, including the right to have, or not to have, children. The former is due primarily to a lack of accessible, affordable and acceptable information and services; the latter to a lack of free and informed choice for women.

15. The need to provide such information and services is self evident. Attaining optimal coverage of reproductive health care requires that people be informed about human sexuality and avoid high-risk sexual behaviour. It further requires that governments remove gender biases in all spheres and provide effective reproductive health care services. Such concerns must be adapted in response to the changing reproductive and sexual health needs of individuals and couples and reflect the social, cultural and economic diversity of the communities being served.

## II. UNFPA PROGRAMME IN 1993

16. The effort to broaden the scope of the UNFPA programme to encompass a more comprehensive reproductive health care approach was one of the most notable features of the Fund's work during 1993. This was accompanied by increasing attention to efforts to satisfy unmet need and to contribute to the empowerment of women, notably as it relates to enhancing women's economic status and exploring the linkages between women's economic activities and reproductive behaviour. UNFPA also sought to strengthen and refine its programming process, focusing on strategic programming and its requisite policy and technical assistance. Each of these areas is explored in some depth below.

### A. Family planning and reproductive health care

17. Three fundamental elements guided UNFPA assistance in this area during the year: improving the quality of family planning programmes; adopting a more comprehensive approach to reproductive health care where family planning services are provided within the framework of reproductive health services; and empowering women in terms of reproductive rights and reproductive freedom. The Fund also formulated a policy paper to guide UNFPA humanitarian assistance during emergencies and other difficult situations. This

assistance is aimed at meeting the reproductive health needs of women and adolescents, especially the most vulnerable among them.

1. Improving the quality of services

18. The quality of family planning services has increasingly been recognized as one of the most important determinants of whether or not people accept and continue to use contraceptives. The Guidelines for UNFPA Support to Family Planning Programmes encourage activities to improve the quality of family planning services, emphasizing the need to expand the availability of such services and to enhance their social acceptability and effectiveness.

19. In 1993, UNFPA organized a thematic evaluation of family planning services in eight countries to determine the extent to which UNFPA-supported programmes complied with these guidelines. Four-person evaluation teams visited selected service delivery points in the following countries: Botswana and Niger in Africa; Indonesia, Pakistan and Viet Nam in Asia; Ecuador and Mexico in Latin America; and Turkey in Europe. The evaluation focused on the quality of family planning services along six dimensions: choice of methods; technical competence of service providers; level of information and counselling available to clients; nature of interpersonal relations between service providers and clients; the presence of mechanisms within the programme to promote continued contraceptive use; and the appropriateness and acceptability of services.

20. The evaluation found that UNFPA's support had contributed significantly to improving women's access to family planning services in the eight countries visited. Family planning services were being delivered in facilities located within a reasonable distance of clients; a variety of contraceptive methods were available; service providers had had some type of training and generally had a positive attitude towards their work and their clients; and basic medical equipment was in place in the facilities. In addition, elementary management systems had been implemented with relative success, enabling most of the facilities to operate smoothly in providing regular family planning services.

21. However, the findings also highlighted several important limitations on the quality of family planning services. For example, the evaluation found that while all eight countries provided at least four methods of contraception (oral pills, intra-uterine devices (IUDs), tubal ligation and condoms), the choice of methods available to clients was limited by various factors, including the tendency among governments and providers to encourage certain methods at the expense of others and the fact that contraceptive services were almost exclusively oriented towards female clients. The evaluation also found that the technical competence of service providers varied greatly; that countries often lacked the basic infrastructure and equipment needed for effective service delivery and that family planning services were sometimes neglected in favour of other health care services. It also noted that the lack of follow-up mechanisms and inadequate record-keeping had limited the capacity of service providers to ensure client satisfaction and effective, continuous contraceptive use.

22. Although most service providers interviewed had had some training in family planning, that training was often insufficient for the services provided. Moreover, service providers seldom screened clients for contraceptive contra-indications or paid adequate attention to clients' complaints about side-effects. Nor did they always diagnose infections properly, provide accurate information or appropriate counselling about contraception or reproductive health, or comply with aseptic procedures during pelvic examinations and IUD insertions. Such deficiencies were compounded by inadequate supervision, which was found often to be too weak, infrequent and insufficient to ensure effective service delivery.

23. Exchanges between service providers and clients were generally friendly but sometimes too brief. In five of the eight countries, clients readily voiced their concerns and fairly easily exchanged information with the service providers. In three countries, however, clients did not get much of a chance to express their needs, feelings or concerns. Service providers either dominated the conversation or tended to give quick and

incomplete answers to questions. In several countries, counselling on sensitive issues frequently took place in front of other clients, and complete privacy during pelvic examinations was not always respected.

24. The evaluation further found that while nearly all UNFPA-supported MCH/FP projects explicitly identified improving the quality of services as one of their objectives, project strategies and activities either did not focus adequately on quality issues or did not specify key indicators that could help in determining whether project inputs were having the desired effect. This contributed to the related problem of placing too great an emphasis on quantity over quality, since programme performance tended to be measured in quantitative terms such as the number of clients served and amount and types of contraceptives provided.

25. The evaluation yielded a number of recommendations, including the following: (a) the mix of contraceptive methods should be sufficiently diverse to meet the needs of all users; (b) choice of method should rest with the user not with the service providers; (c) more emphasis should be placed on promoting male contraception; (d) particular attention should be given to providing clients with complete, accurate and understandable information on available contraceptive methods; (e) service providers should be trained on the job in clinical skills and in interpersonal communications and counselling; and (f) mechanisms to ensure adequate follow-up of family planning acceptors should be developed or strengthened and, within this context, practical and simple record-keeping systems should be developed and institutionalized; and (g) supervisors should be trained to monitor the quality of the services delivered (rather than just the outcomes as indicated by service statistics) and to give technical advice in a supportive way.

Financing family planning services

26. The cost of providing family planning services is escalating each year, as more and more couples opt to use contraception and the number of women entering reproductive age increases as a result of the built-in momentum of past growth rates. At present, governments assume about 60-75 per cent of these costs. The international donor community provides some 15-20 per cent. The remaining 10-15 per cent is absorbed by the users themselves or provided through non-governmental organizations (NGOs).

27. Even if governments and donors were to increase their support for family planning substantially, there would still be a need to devise means to help alleviate the growing pressure on resources. As a result, UNFPA has been exploring new ways of sharing the costs of family planning programmes. One option is to shift a portion of the costs of such services to individual users through effective cost-recovery schemes. Recent research suggests, however, that the share of total resources absorbed by for-profit schemes has remained static or has even declined. In some cases, such schemes have been "crowded out" by government and NGO programmes. In fact, one study commissioned by UNFPA noted that the very success of government and NGO programmes had made it difficult to encourage the use of the private sector.

28. During 1993, UNFPA provided support to prepare case studies on cost-recovery schemes in six countries -- Brazil, Colombia, Egypt, Kenya, Indonesia and Thailand -- and to conduct an in-depth review and appraisal of relevant experiences and lessons learned in this area at the global level. The review of global experiences was not particularly optimistic about the prospects of shifting a significant share of the funding of family planning programmes from governments and donors to the private sector. But it did note that the results of some individual projects had been encouraging. The review concluded that additional research was needed to determine what types of private-sector expansion would work best in particular countries.

29. The issues raised in these studies were discussed at an International Consultation on Cost Recovery and Family Planning Programme Sustainability, which was held at United Nations headquarters in March 1994. Experts from developing countries participated in the consultation, as did representatives from United Nations agencies and organizations and from NGOs. The participants examined the role of the private sector in contributing to the sustainability of national family planning programmes, including pharmaceutical companies, contraceptive social-marketing programmes and employer-provided programmes, among others. They also

addressed the issue of the sustainability of public-sector and NGO programmes, and identified areas requiring further research. Participants generally agreed that pharmaceutical companies had, in some cases, become successful partners with NGOs, donors and governments in marketing and distributing contraceptives; that contraceptive social-marketing programmes targeted at middle and lower-middle socio-economic groups should receive limited subsidy while those targeted at the lowest socio-economic groups would always need some subsidy to generate demand; and that successful employer-provided programmes required committed company managers, strong technical and logistical support, good financial health, large numbers of covered employees and dependants, and the participation of a strong NGO to provide services.

2. Integrating family planning into reproductive health care

30. UNFPA regards family planning as an essential component of reproductive health care. The Fund recognizes that family planning programmes work best when they are linked to broader reproductive health programmes and when women are fully involved in the design, delivery, management and evaluation of services. UNFPA therefore promotes an integrated programme approach that seeks to make family planning services available to all who need and want them and to help couples and individuals satisfy their reproductive needs and goals.

31. The challenges in the area of reproductive health care/family planning range from understanding people's fertility behaviour and satisfying their family planning needs, to preventing unsafe abortion, to aggressively combatting the spread of STDs and HIV/AIDS. Meeting these challenges requires designing and implementing innovative and effective ways of delivering integrated services to all those who desire them, but especially to hard-to-reach populations and those at increased risk of STD/HIV infection. Such services must be extended to poor women, minorities, unmarried women and adolescents; promote healthy and responsible reproductive behaviour; pay special attention to young adults and men; and promote the use of condoms and other barrier methods of contraception.

32. In a policy note on reproductive health care, UNFPA proposes to support countries' efforts towards integrated reproductive health care/family planning services, to be provided through primary health care systems. These include: (a) information and services aimed at all couples and individuals, including adolescents; (b) treatment of gynaecological problems related to contraception; (c) information, education and services dealing with prenatal and postnatal care as well as with childbirth; (d) information and services regarding the prevention of STDs, including counselling, distribution of condoms for HIV/AIDS prevention and referral services for follow-up care; (e) diagnosis and treatment of infertility and sub-fecundity and referral for follow-up; and (f) routine reproductive health check-ups for women.

33. UNFPA recognizes that it will be difficult to satisfy women's family planning and reproductive health needs without the support of men, not only as husbands and partners but also as policy and decision makers and community and religious leaders. Efforts to involve men as responsible partners in helping to satisfy such needs take on a special urgency given the rapid spread of HIV/AIDS and the potential improvement in reproductive health that would follow if programmes promoted male participation as well as male methods as part of the contraceptive choices available to couples. The Fund further recognizes that integrated programmes must address the family planning and reproductive health concerns of adolescents, who urgently need information and services that can help protect them from unwanted pregnancies, unsafe abortion and sexually transmitted diseases.

HIV/AIDS prevention activities

34. The prevention and treatment of sexually transmitted diseases, including HIV/AIDS, is an integral component of reproductive health care. It is also an important concern of the UNFPA programme and a focus of considerable inter-agency collaboration.

35. During the year, UNFPA helped organize a round table to discuss the impact of HIV/AIDS on population policies and programmes, which was held in Berlin in September/October 1993 under the auspices of the Policy Development Forum of the German Foundation for International Development. The Fund prepared the main background document for the round table, which was organized as part of the preparatory process for the International Conference on Population and Development (ICPD). The round table recommended, among other things, that governments and the international community should commit themselves to fight against HIV/AIDS as an essential part of sound population and related family planning policies. It took issue with the view held by some "that AIDS will take care of the population problem", calling it "completely erroneous". The round table called for a "firm political commitment to women's empowerment" and stressed the need to enhance women's ability to take control over their own reproductive and sexual lives.

36. UNFPA also participated in inter-agency discussions on the feasibility and practicability of establishing a joint and cosponsored United Nations programme on AIDS, as called for by the World Health Assembly in resolution WHA 46.37. The study that emerged out of these discussions was presented to the WHO Executive Board, which recommended that the joint and cosponsored programme be established.

37. In 1993, the Fund prepared and distributed the 1992 AIDS Update, an annual publication highlighting UNFPA's support for HIV/AIDS prevention activities around the globe. The Update provided information on UNFPA assistance in four areas: supply of condoms; training for MCH/FP service providers; HIV/AIDS information and education as part of in- and out-of-school population education programmes; and public information and education activities. The 1992 AIDS Update was sent to representatives of governments, NGOs and academic institutions and was distributed at the fortieth session of the Governing Council and the IX International Conference on AIDS held in Berlin in June.

38. UNFPA worked closely with the WHO Global Programme on AIDS (WHO/GPA) in preparing estimates for condom requirements for HIV/AIDS prevention as part of in-depth studies in the Philippines, Turkey and Viet Nam undertaken within the framework of the Fund's Global Initiative on Contraceptive Requirements and Logistics Management Needs in Developing Countries in the 1990s. UNFPA also prepared, in collaboration with The Population Council, an update of the global estimates of contraceptive requirements for 1994-2005, which included estimates of condom requirements for STD/AIDS prevention, prepared by WHO/GPA. A summary of the findings of the update are provided in document DP/1994/47, which is being submitted to the Executive Board at its first annual session.

### 3. Strengthening IEC in support of family planning

39. The concept of information, education and communication (IEC) was initially developed by health planners in the 1960s in order to create demand for reproductive health care and family planning services. IEC activities were aimed at both service providers and users and sought to narrow the gap between the knowledge and use of family planning services. This was to be accomplished through a combination of information and education (knowledge-based) activities and communication (motivation) activities. The aim was to change people's behaviour.

40. IEC activities evolved over the next several decades to become an essential component of family planning programmes. They helped to generate political commitment and obtain community support; train service providers in interpersonal communications and motivational skills; inform potential clients about the availability of services; change people's perceptions of family planning and create demand for services; improve the quality of services; and, ultimately, enable clients to make free and informed decisions regarding their choice of method.

41. The success of IEC activities depends, among other things, on how well they are tailored for each respective audience. Programme managers and service providers, for example, need information that enables them to select, promote and deliver the most appropriate services to the various audiences they serve.

Potential clients have to know what services are available and where, how and when they can get them. Current users need information to enable them to make the best choice of method, given their changing circumstances. Potential and current users both need to know the risks and benefits of each method and be well enough informed to be able to disregard rumors and misinformation.

42. In order to assess the strengths and weaknesses of IEC activities in support of family planning programmes, UNFPA organized a thematic evaluation of seven IEC projects in five countries: Comoros, Rwanda and Zambia in Africa; and India and the Philippines in Asia. The projects fell into two categories: MCH/FP projects with an integrated IEC component; and IEC projects specially designed to support MCH/FP activities. The evaluators also drew upon evaluation and programme review reports on nine additional projects to obtain supplementary information.

43. The evaluation found that both types of projects had contributed to improving the level of knowledge and practice of family planning. In general, however, the projects were found to be overly ambitious, with too many objectives and an unrealistic time frame within which to achieve them -- a not uncommon problem with projects in other sectors as well. Moreover, indicators of success tended to be quantitatively rather than qualitatively oriented. In the projects with IEC components, it was not always clear how the IEC component would be integrated into the MCH/FP activities. The support IEC projects, on the other hand, did not usually ensure that the demand created would be matched by the services provided. In fact, the evaluation found that coordination in general tended to be weak -- not only between service delivery and IEC activities in MCH/FP projects with integrated IEC components, but also between MCH/FP and IEC project personnel more generally.

44. In recognition of the importance of strengthening the link between MCH/FP and IEC activities, UNFPA prepared a technical note on the relationship between IEC and family planning service delivery. The note identifies six prerequisites for success. The first is collaborative planning. Service providers and IEC personnel must work closely together to identify the behavioural and attitudinal changes desired and the different population groups to be addressed. The second is strong and effective intra- and inter-sectoral coordination. The third is complementary mass-media and interpersonal approaches: The use of mass media helps to legitimize and disseminate IEC messages; the use of interpersonal communications personalizes them. The fourth is a sound service delivery system capable of meeting the demand generated by the IEC activities. The fifth is the effective integration and coordination of IEC and family planning activities. The sixth is the incorporation of monitoring and evaluation mechanisms in project design.

45. The Fund also issued a technical paper on developing IEC strategies for population programmes. The paper enumerated a 12-step approach to designing an effective strategy, which if applied in the project formulation, appraisal and monitoring stages would specifically address most of the shortcomings identified in the thematic evaluation. It also identified lessons learned from the Fund's experience in population IEC, including those specifically oriented towards users of family planning and reproductive health services. Not surprisingly, good interpersonal communication and counselling skills were found to be a prerequisite to effective and continued use of MCH/FP services, increased contraceptive prevalence and the acceptance of safer sexual practices. The technical paper is available in Arabic, English, French and Spanish.

### 4. Linking women's economic activities and reproductive behaviour

46. Economic independence for women has long been recognized as a key to limiting fertility. The ability to earn income helps to create alternatives to early marriage and early and frequent child-bearing. It also increases the opportunity costs of women's time and the "cost" of children, enhances women's status and self-esteem, and increases a woman's ability to make her own decisions, including those concerning child-bearing and contraception.

47. One of the ways in which UNFPA seeks to link family planning activities with efforts to enhance women's ability to earn income is through experimental projects that help women set up micro-enterprises. The projects typically help women secure credit, provide technical assistance and training in managing small businesses, and promote the use of family planning. Micro-enterprises are unincorporated business activities that are undertaken by individuals, households or groups and require a limited number of employees. They are generally part of the informal sector and include such things as off-farm employment, manufacturing and commerce.

48. In early 1993, UNFPA published a comprehensive assessment of the Fund's experience with micro-enterprise projects for women. The report culminated a year-long thematic evaluation that began with the development of an evaluation methodology, involved a desk review of all available documentation on 19 such projects, and ended with four evaluation missions to project sites in six countries -- Egypt, Ghana, India, Kenya, Paraguay and the Philippines. The missions reviewed all primary and secondary project documentation, including loan records and project monitoring data; conducted focus-group interviews; visited client enterprises; and interviewed representatives of government agencies and non-governmental organizations.

49. The evaluation did not find precise data to affirm a direct link between increased income and reduced fertility. However, it did show that when project inputs reached women and when women had access to family planning services, the projects appeared to contribute to increases in income and changes in reproductive behaviour. It also found that increases in income can accelerate demand for family planning and maternal and child health services. At the same time, however, the evaluation showed that population projects with micro-enterprise and income-generation components require specialized technical expertise to design and a strong institutional capacity to implement, both of which made the selection of implementing and executing agencies critical to the success of the activity.

50. The evaluation recommended that UNFPA should continue to support micro-enterprise projects for women, giving preference to micro-enterprise activities that clearly helped to achieve population objectives and that linked population components to strategies that had proven effective in increasing women's income. The evaluation further recommended that UNFPA-supported projects should have explicit linkages to the Fund's country-level population programmes, especially to MCH/FP or other activities that seek to enhance women's reproductive rights, and ensure that there are family planning services available to meet the demand generated by the projects. The evaluation stressed that, as a primary strategy, UNFPA should introduce MCH/FP, as well as IEC and other population components, into existing micro-enterprise programmes and projects rather than design separate micro-enterprise/population projects on its own. In this context, the Fund should identify executing agencies that have the requisite technical capacity to ensure that projects are well designed, monitored and implemented, and select implementing agencies that have a proven track record in micro-enterprise activities.

### B. Strategic programming and technical assistance

51. The review and assessment of programme strategies and the evaluation of programme performance are part of a continuum to enhance the impact and effectiveness of programmes. They are also at the core of the Fund's programme review and strategy development (PRSD) exercise. Programme performance and effectiveness, in turn, are enhanced by high-quality technical assistance. The Fund's principal mechanism for providing such technical assistance at the country level is the UNFPA Country Support Team (CST), of which there are currently eight in operation. The work of the teams is complemented by specialists and coordinators located at the United Nations and its regional commissions, at the headquarters of United Nations specialized agencies and at WHO regional offices.

### 1. Programme review and strategy development

52. In 1993, UNFPA reviewed its experience with the PRSD exercise. The objective was to identify ways to further strengthen the effectiveness of the exercise and to make optimal use of the findings and recommendations in the formulation of corresponding country programmes.

53. The review found that the PRSD exercises had yielded a wealth of data, enhanced the understanding of the population dynamics in the countries reviewed, and facilitated the planning, design and implementation of national population programmes. It further found that the objectives and strategies of the corresponding UNFPA country programmes were clearly based on the PRSD recommendations. However, the review suggested ways to improve the usefulness of the recommendations, both by making them more explicit and by establishing clear priorities. Although the recommendations generally were found to be specific to the needs of the country reviewed, it was recommended that the strategies developed should be more comprehensive and take greater account of analyses of national capacities in various sectors, constraints to population programme implementation, and the overall national development context.

54. In general, the approach to the PRSD exercise was found to be too mission-driven. Much energy and attention were focused on activities specific to organizing and conducting the PRSD mission, but not enough on critical preparatory and follow-up activities. Nonetheless, the missions more effectively achieved their purpose when the Government was actively involved in the process and when the missions worked in close collaboration with the UNFPA field office.

55. The review reaffirmed the PRSD exercise as a powerful approach to population programming. The lessons learned from the review will be used to help strengthen the Fund's programme development process. UNFPA will thus take care to generate and maintain population programme data on a country-by-country basis; clearly define the roles and responsibilities of those involved in the process; clearly delineate the various phases in the programming process; and refine and improve the tools used in programme monitoring and evaluation.

### 2. UNFPA Country Support Teams

56. During 1993, UNFPA Country Support Teams fielded missions to close to 100 countries. The teams participated in selected PRSD exercises (e.g., Chad, Islamic Republic of Iran, Maldives, the Philippines, and Zambia) and in tripartite project reviews; helped to formulate and appraise selected country projects; and assisted UNFPA field offices in monitoring country programmes. Team experts also pooled their technical expertise in joint programming missions in Bangladesh, Chad, China, Lao People's Democratic Republic, Mali, Syrian Arab Republic and Viet Nam.

57. The CSTs continued to make use of national expertise and national institutions as a source of technical assistance in implementing population activities. The teams therefore prepared rosters of national experts to be used as consultants and trained national counterparts, both formally, through workshops, and informally, as participants/observers on collaborative technical assistance missions.

58. An inter-agency task force met in March to discuss policy and operational issues that arose during the first full year of operations. Such issues included, among others, questions concerning the division of labour between the various actors involved in country-level activities (representatives of government agencies and United Nations specialized agencies, team members, UNFPA Country Directors) and the nature of the relationship between CST advisers and their parent agencies. The task force also discussed the need to improve the quality of technical back-stopping plans, which are intended to guide the work of the teams in each country; to clarify issues concerning the cost to country budgets of the teams' services; and to identify issues to be addressed in matching, on a regional basis, the needs of countries and the skills represented on the teams.

59. The interagency task force met again in December to review the TSS recruitment process and to assess the performance of the TSS specialists at agency headquarters as well as of the advisers on the teams. A review of the distribution of TSS posts vis-à-vis country needs resulted in the transfer of two ILO headquarters specialists posts to the CST in Santiago, Chile, to enable it to respond more efficiently to requests from the English-speaking Caribbean countries. The task force also re-defined several CST posts in Africa in order to meet the needs expressed by governments, especially in the areas of socio-cultural research, management information systems (MIS), and IEC in support of family planning and reproductive health care.

60. All eight CSTs became fully operational in 1993. In sub-Saharan Africa, in March, members of the three teams in Africa and staff from UNFPA headquarters participated in a workshop in Addis Ababa to review substantive and procedural matters. In September, the Harare-based team hosted a joint workshop with the UNFPA Country Directors from the subregion it serves in order to review collaborative strategies for providing technical support to country programmes. The Addis-based team hosted a similar workshop in December. The workshops provided the teams and Country Directors with the opportunity to reach a common understanding on many organizational and operational matters. CST/Dakar organized several internal seminars to brainstorm with colleagues from United Nations specialized agencies, the World Bank and NGOs active in the population field. The participants assessed the work of the team and made recommendations in each of the areas covered by team specialists. In a number of countries, including Ghana, Uganda and Zambia, team members participated in joint missions that drew upon their multi-disciplinary skills to help develop a less narrowly focused, more integrated programmatic approach to UNFPA assistance. In general, the teams, among many other things, helped to identify needs for logistics support to MCH/FP, formulate population education activities aimed at in- and out-of-school youth, develop IEC strategies, and provide technical back-stopping for census operations and analysis.

61. The CST based in Amman, Jordan, provided technical support to the country programmes in the region. During the year, team members undertook more than 85 missions to provide technical assistance to 20 countries, in particular in the areas of MCH/FP, IEC, and data collection and analysis. The team also responded to an increasing number of requests for technical monitoring of ongoing projects. CST/Amman, among many other things, revised a project document on strengthening the administration and management of the MCH/FP programme in the Syrian Arab Republic; provided technical support to strengthen the training activities of a project to expand family health services as a component of primary health care (Syrian Arab Republic); helped formulate two projects in Egypt -- one to strengthen family planning services in Aswan; the other to provide family planning services in remote areas in Aswan Governate; assisted in designing a questionnaire for a migration and labour force survey in Sudan; provided technical back-stopping for a project on family welfare planning, education, motivation and services in industrial areas of Khartoum; and helped reformulate a project to expand and upgrade MCH/FP services in Yemen.

62. The three CSTs in the Asia and Pacific region carried out nearly 150 technical advisory missions in over 30 countries. The teams worked closely with UNFPA Country Directors in providing technical assistance to help build national capacities in the areas covered by the UNFPA country programme. CST Suva, for example, undertook 41 technical back-stopping missions in support of IEC activities, population and development planning, and data collection, analysis and dissemination. The team also published a handbook on "A New Approach to Technical Support Services in Population" and assisted six Pacific island countries in preparing country reports for the ICPD. CST/Kathmandu organized focus-group discussions in Nepal on women's reproductive health care and family planning concerns and provided technical assistance on population education activities in the non-formal sector. It also reviewed several IEC project proposals in India, Nepal and Pakistan. The team worked with the Government of Maldives in analysing census data and with the Government of Bhutan in preparing a comprehensive profile of safe motherhood. At the regional level, it helped organize the South Asia Association for Regional Cooperation (SAARC) Ministerial Conference on Women and Family Health, for which it also prepared background documents. CST/Bangkok worked closely with the UNFPA field office in Viet Nam in developing a management information system for contraceptive supplies and in formulating a comprehensive population education project. It assisted the

Government of Cambodia in formulating a project on MCH/birth spacing; helped train 22 high-level Chinese educators in planning population education programmes; and provided training and orientation for three senior Mongolian officials in various aspects of population and development planning. The team also organized a Round Table on Population and Development Strategies as part of the ICPD process.

63. The CST headquartered in Santiago, Chile, carried out 125 missions from the 170 requests it received. The team provided technical support to country programmes and projects in the areas of MCH/FP, IEC, population and development, and data collection and analysis. The team's overall strategy was to ensure that the technical assistance provided was sharply defined and relevant to the needs of the populations being served. In the area of reproductive health and family planning, the team helped train 110 professionals in programme management, focusing on such areas as leadership techniques, planning and evaluation. Team specialists in IEC conducted several joint missions with project counterparts as a way of sharpening the focus of the IEC portion of specific projects. One of the aims has been to try to make IEC activities relevant to the everyday lives of the people and to extend the coverage of IEC messages to rural and urban workers, cooperatives and women's and youth organizations. Team specialists in population and development helped to design research projects addressing the special needs of women, adolescents and indigenous communities. Team specialists in the area of data collection and analysis emphasized efforts to improve national capacities to obtain and utilize demographic data to support the implementation of decentralized social policies.

## III. STATUS REPORT ON UNFPA IMPLEMENTATION OF GENERAL ASSEMBLY RESOLUTION 47/199

64. This status report has been prepared in response to Governing Council decision 93/27 A, paragraph 8, which requested the Executive Director to report to the Council at its forty-first session (1994) on the progress made in the further implementation of General Assembly resolution 47/199.

65. During the latter part of 1993, UNFPA built upon the progress made in the first part of the year, as reported on last year in document DP/1993/29, part III. For example, the Fund continued to address relevant concerns of resolution 47/199 in all policy planning, programming and training exercises, including, most notably, those dealing with the country strategy note (CSN), harmonization of programming cycles, the programme approach, national execution and national capacity building, decentralization, and training.

66. UNFPA also continued to work closely with United Nations partner agencies and organizations through its involvement in the Joint Consultative Group on Policy (JCGP), the Consultative Committee on Programme and Operational Questions (CCPOQ) and the Consultative Committee on Administrative Questions (CCAQ) of the Administrative Committee on Coordination (ACC), and relevant inter-organizational training exercises at both the country level and the global level, notably the ILO International Training Centre in Turin.

67. Country strategy note. UNFPA participated in JCGP and CCPOQ working groups to draft initial guidelines covering United Nations contributions to the country strategy note. In October 1993, selected UNFPA field staff participated in a workshop held at the Turin International Training Centre as part of the process to draft system-wide guidelines. UNFPA was also a key partner in the National Workshop on Coordination for Senior United Nations Representatives based in the Syrian Arab Republic, organized by the Turin Centre and UNDP Damascus under the auspices of the Syrian Arab Republic Ministry of State for Planning Affairs. The workshop produced a joint work programme on the CSN process. In addition, UNFPA, UNDP and UNICEF agreed to fund an umbrella project on a United Nations system integrated approach to technical assistance activities in support of the CSN process. In May 1994, the Fund will act as lead agency in the Turin Centre's 12th Management Coordination Workshop, a major purpose of which is to ensure that population issues are integrated into CSN exercises.

68. Harmonization of programming cycles. As follow-up to the 1993 joint letter sent by the executive heads of UNICEF, UNDP and UNFPA to their respective field offices, UNFPA convened working groups on harmonization of programming cycles for Latin America and the Caribbean and for the Middle East and North Africa. The working groups prepared recommendations for such harmonization and sent them to UNFPA Country Directors for comments.

69. Programme approach. UNFPA continued to participate in JCGP and CCPOQ efforts to develop a framework to help United Nations agencies and organizations reach an agreement on a system-wide interpretation of the programme approach. In 1993, in Egypt, UNICEF, UNDP and UNFPA signed an agreement on an integrated development package with the Governate of Assiut. In Bangladesh, UNICEF and UNFPA are working on an integrated planning model, which will include modules on literacy, nutrition, health and women's status. In 1994, UNFPA will participate in study missions to selected countries being organized by the United Nations.

70. National execution and national capacity building. The UNFPA Country Support Teams continued to make use of national expertise and national institutions as a source of technical assistance in implementing population activities. The teams prepared rosters of national experts to be used as consultants and trained national counterparts, both formally, through workshops, and informally, as participants/observers on collaborative technical assistance missions. National execution of projects is also stressed in the UNFPA country programmes being submitted to the Executive Board at its first annual session.

71. Decentralization. UNFPA revised its guidelines on decentralization, considerably expanding programme approval authority at the field level. Moreover, the Fund has extended total programme approval authority, on a trial basis, to 12 countries (Algeria, Bangladesh, Burkina Faso, Ethiopia, Honduras, Malawi, Pakistan, Peru, Philippines, Senegal, South Pacific subregion, and Syrian Arab Republic). UNFPA will extend such approval authority to other countries if the pilot experiences warrant it. The Fund also recently decentralized travel arrangements to the field for UNFPA consultants hired in the field.

72. Training. UNFPA supports and will continue to participate in relevant inter-organizational training exercises at the country level and at the International Training Centre in Turin. The Fund contributes funding, training advice and expertise to help strengthen the Centre's work on collaborative training for the United Nations system. In April 1994, UNFPA participated in the Workshop on the Programme Approach at the Centre. The Fund will also act as lead agency in the Centre's 12th Management Coordination Workshop, which will highlight population issues. In Bangladesh, the JCGP partners have agreed to pursue an integrated approach to training of United Nations staff.

73. Evaluation and Management Audit. UNFPA participates in the Inter-Agency Working Group on Evaluation, which is currently reviewing elements for collaboration in the area of evaluation. UNFPA also participates in the JCGP Working Group on Management Audit Systems. The Working Group submitted a report to the JCGP, highlighting common elements and standard auditing practices among the partner JCGP organizations. The Working Group also adopted a common definition of management auditing. The report was accepted as the basis for reporting to the Economic and Social Council on management audit systems within the context of resolution 47/199.

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